Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $72,032.52 for dates of service 10/04/01 through 10/08/01.

   b. The request was received on 01/03/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 09/11/02
   b. HCFA-1450s
   c. TWCC 62 forms
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 10/04/02
   b. HCFA-1450s
   c. TWCC 62 forms
   d. SOAH Decision
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 09/19/02. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 09/20/02. The response from the insurance carrier was received in the Division on 10/04/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor:

The requestor states in the correspondence dated 09/11/02 that…
"The patient named above was admitted for spinal surgery on 10-4-01, for which there was preauthorization. Due to the nature of the surgery, the patient was admitted for inpatient care and was not released until 10-8-01. The total facility charges for treatment provided 10-4-01 through 10-8-01 was $117,873.20. Upon our original billing of the carrier… our facility received an initial payment of $39,926.60. They did not pay anything on the supply/implant charges because we did not submit the implant invoices with the original bill. Our facility did, however, submit the implant invoices with our request for reconsideration. We requested that the implant invoices be reviewed and that we be paid using the Stop-Loss Reimbursement Factor of 75% since the total audited charges did exceed the stop-loss threshold of $40,000. The carrier allowed additional payment, in consideration to the implant invoices in the amount of $6,950. We contacted the carrier to inquire about how they paid on the implant invoices. They explained that they paid the original payment based on the stop-loss method of 75%. In examining the explanation of benefits, calculations will show that the stop loss excluded all charges for the supply/implants. In examining the explanation of benefits for the additional payment it is clear that the carrier did not pay the supply/implants at a stop loss but rather at cost plus 10%. It is clearly states in Chapter 134, of the Texas Workers' Compensation Commission, Abridged Rule 134.401 (c6), that the stop-loss method shall be used in place of and not in addition to the per diem based reimbursement system. Covered under the same rule, in (c)(6A(v))[sic], it states that audited charges are those charges which remain after a bill review and that the only charges that should be deducted from the total charges to be included in the stop-loss are personal items, charges for services not documented, and services not related to the compensable injury. Upon our request for reconsideration, the implant invoices were submitted and provided sufficient documentation and should not have been deducted from the total charge, but rather a recalculation should have been done using the Stop-Loss Reimbursement Factor of 75%."

2. Respondent:

The Respondent in the correspondence dated 10/04/02 states that...
"Provider appears to be taking the position that it is entitled to reimbursement of 75% of its total billed charges under the stop-loss provisions of the 1997 *Acute Care Inpatient Hospital Fee Guideline* ('*Guideline'*). However, Provider is not entitled to reimbursement of 75% of its total billed charges for the following reasons. On 10/4/01, the Claimant was admitted to the Provider's facility for surgical care. For the three-day inpatient stay and surgical procedure, the Provider submitted a bill to the Carrier for $117,873.20, which included a $64,701.70 charge for implantables. The Carrier reimbursed the Provider $46,877.50 calculated in accordance with the *Guideline*. See Payments, attached as **Exhibit 1.**

Of the $64,701.70 billed for implantables, $8,308.00 was for a 'graft bone bank' and $56,393.70 was for a 'spinal fixation.' *See* Itemized Statement at p.1, attached as **Exhibit 2.** Provider billed Carrier $64,701.70 for items that cost it a total of $6,319.00, resulting in a grossly excessive mark-up of more than 1000%. *See* Invoices, attached as **Exhibit 3.**

As part of its audit, the Carrier properly reduced Provider's grossly inflated charges for the implantables to the cost of the implantables plus ten percent. *See, e.g,* SOAH Decision and Order, Docket No. 453-00-2092. M4 (ALJ…April 24, 2001) (holding that a carrier should be allowed to reduce charges for implantables to cost plus ten percent-'Allowing hospitals to set their own charges for implantables and then removing carriers' abilities to audit charges, thereby forcing them to pay inflated bills, leads to absurd results.'), attached as **Exhibit 4.** Reducing Provider's charges for the implantables to cost plus ten percent, results in a figure of $6,950.90 ($6,319.00 + $631.90 = $6,950.90). After reimbursing various medical/surgical supplies and blood storage at a fair and reasonable rate, the Carrier also reimbursed the remaining charges at 75% of the billed charges, or $39,926.60. Total reimbursement for this three-day stay was $46,877.50 ($39,926.60 + $6,950.90). *See* Explanations of Benefits, attached as **Exhibit 5.**

Carrier maintains that it is entitled to reduce Provider's charges for implantables to cost plus ten percent. Such a reduction is fair and reasonable and is consistent with the intent of the *Acute Care Inpatient Hospital Fee Guideline.* In the preamble to the inpatient fee guideline, the Commission stated that 'implantables are to be reimbursed at cost to the hospital plus 10% of the cost to ensure that the cost of the item and related overhead costs are covered by the reimbursement. This method of reimbursement for revenue code carve outs is the predominant method used in the 1994-95 hospital contracts.' *Guideline,* at p.23."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 10/04/01 and extending through 10/08/01.

2. The Provider billed the Carrier $117,873.60 for the dates of service 10/04/01 and extending through 10/08/01.

3. The Carrier made a total reimbursement of $46,977.50 for the dates of service 10/04/01 and extending through 10/08/01.

4. The amount left in dispute is $70,996.10 for the dates of service 10/04/01 and extending through 10/08/01.

V. RATIONALE

Medical Review Division's rationale:

The medical reports indicate that the services were performed. The medical documentation submitted by the Requestor indicates that the total hospital bill was $117,873.60. Per Rule 134.401 (c)(6)(A)(i)(iii), once the bill has reached the minimum Stop-Loss threshold of $40,000.00, the entire admission will be paid using the Stop-Loss Reimbursement Factor (SLRF) of 75%. Per Rule 134.401 (c)(6)(A)(v), the charges that **may** (emphasis added) be deducted from the total bill are those for personal items (television, telephone), those not related to the compensable injury, or if an onsite audit is performed, those charges not documented as rendered during the admission may be deducted.

The carrier is allowed to audit the hospital bill on a per line basis. The Carrier denied "Hospital Services" as "F-REIMBURSEMENT WAS CALCULATED USING THE STOP LOSS METHOD. S-SUPPLEMENTAL PAYMENT. N-Not Documented."

According to TWCC Rule 413.011(d):
"Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The provider has submitted two purchase orders that indicate evidence of the cost of the implants. The total indicated is $2,680.00 for Crushed Cancellous/30cc on one order and $3,639.00 for implantables on the other. The total of these two orders is $6,319.00. The provider indicates on the submitted UB-92 a total charge of $64,701.70 for the total cost of the implants. Based on the information provided by the requestor, it would not appear that effective cost control has been achieved by a 1000% mark-up on the implantables. The stop-loss total charges are $117,973.60, which includes the implantables. If you deduct $64,701.70 from the total billed charges ($117,973.60) this would make the charges $53,271.90. The Carrier indicted that a mark-up of "40-45% would be usual and customary." The Carrier indicated that a 45% mark-up would result in a reimbursement of $9,162.55 for the implantables. The stop-loss reimbursement would then be $53,271.90 plus $9,162.55, which equals ($62,434.45 x .75 = $46,825.84). The Carrier already reimbursed the Provider $46,877.50. The amount reimbursed by the Carrier is $46,877.50.

Therefore, **no** further reimbursement is due.

The above Findings and Decision are hereby issued this 21st day of October 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb